A Systematic Approach To Provider Based Disability Management

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Abstract

Tacit within the treatment goals of every workers' compensation case is timely return of the worker to pre-injury status. Assigned disability status must truly reflect the extent of medical impairment and functional limitations affecting return to his/her customary job. Permanent Partial Disability (PPD) awards with associated legal involvement are widely acknowledged as a major cost driver within the Workers' Compensation system. Medical providers are encouraged to become pro-active disability management specialists for each workers' compensation case. Provider review of critical process checkpoints and integration of medical treatment with disability guidelines maximize benefits to the injured employee and the employer. This in turn enhances providers' control of patient care with less emphasis on external case managers.

For the past half century, workers' compensation has stood as the primary medical and wage loss replacement system for workers injured on the job. Injuries and illnesses *arising out of and during the course of employment* constitute the definition of a work-related injury.[1,2] On filing an injury claim, the employee promulgates entry into a complex medicolegal system of care. The workers' compensation system provides the legislative construct, integrating medical treatment of the injury/illness with wage replacement for lost work capabilities. Medical management of workplace injuries has shown relatively little change. Emphasis continues to be placed on subjective symptom cures, as opposed to objectively, based clinical endpoints of anatomical/physiological function and work capability. This dichotomy in treatment management underlies why work-related injuries and illnesses remain prevalent as a significant proportion of employer cost.

Ideally, appropriate medical treatment integrated with motivated return to work should be complementary. However, these goals often become diametrically opposed and compromise final outcomes. The medical provider orchestrates an often complex treatment process that concludes when the employee reaches maximum medical improvement and work capability.

Disability Divergence

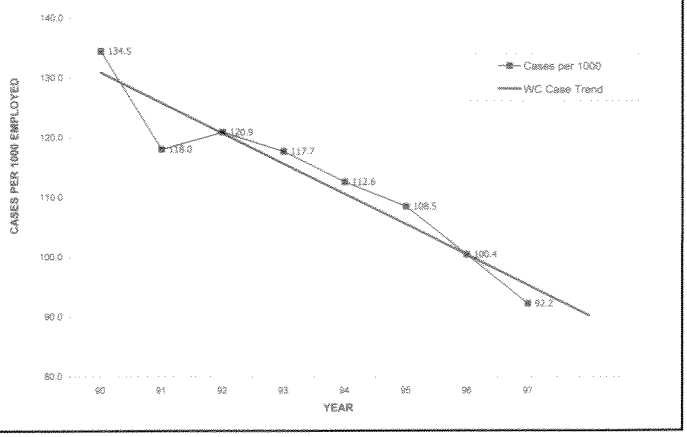
The term *disability management* reflects the planned minimization of *days away from work* or *days on restricted work activity* as a medically appropriate and beneficial aspect to injury/illness recovery. While a given degree of impairment may be closely corroborated by experienced providers, assignment of disability often differs widely. Disability management, more frequently than not, reflects a process of negotiation between the injured worker and the medical provider. What an injured person asserts as his/her functional capabilities and what the physician affirms as work limitations often results in a gap between perceived work capabilities and assigned work duty status.[3] The gap in perception of disability between the participants in a workers' compensation case may be termed a *disability divergence*. It frequently evolves into a negotiation of work duty status between the injured worker and treating provider. When disability divergence occurs, it can have the effect of reinforcing the injured role, protracting disability, and increasing case costs.

Hawaii Workers' Compensation Costs

In 1995, Hawaii enacted legislation aimed at reducing the upwardly spiralling costs of workers' compensation insurance. One initiative included emphasizing safety incentives for employers to reduce worksite injuries. Additionally, the workers' compensation medical fee schedule was reduced by 54% and based on 110% of Medicare. From 1995 through 1998, total workers' compensation costs did in fact fall from an all time high of $343,079,773 in 1994 to $233,224,525 in 1998. At the same time however, the number of processed cases dropped from 61,353 in 1994 to 45,910 cases in 1998.[4] Normalizing to a rate of workers' compensation cases per 1000 employed demonstrates essentially the same negative slope line between 1990 and 1997(Figure 1). Clearly, the decline in cost paralleled the progressive reduction in volume of processed cases. Review of national workers' compensation data revealed a similar trend for declining volume of injuries.[5] This would seem to call in doubt the presumption that legislative change made any significant impact on cost containment. Instead, it would appear that legislation simply occurred serendipitously at a point when a declining trend of workers' compensation injuries was already occurring.

Deeper analysis of the declining case and cost trends reveals interesting insights. First, despite declining total costs, average cost

Figure 1.— Trend of WC Cases Per 1000 Employed, 1990-1997



per case remained relatively constant with a hint of an upward trend in 1998. Secondly, workers' compensation cases with medical involvement represented 62% of total cases though actual medical care represented only 37% of total costs. In comparison, temporary total disability, temporary partial disability, and permanent partial disability represented 31% of cases but 51% of total costs (Figure 2). Though these figures are specific to 1998 they are closely representative of the period from 1990-1997.[4] The contribution of disability as the major factor in total cost of a workers' compensation case brings to focus the need for a reliable model of provider-based disability management (PBDM).

Critical Checkpoints

Improvements on the process of providing medical care for the injured worker have focused on diagnosis-specific guidelines for reducing medical cost and length of disability.[6] These guidelines are primarily based on large aggregate populations. Though this approach has produced an increased awareness by medical providers of the necessity for prudent medical management of work-related injuries, it falls short on providing a clinically useful, easily applicable model for an individual case.[7] Physician-directed disability control is key in achieving successful clinical outcomes. A standard approach is suggested, based on review of critical checkpoints and integration of medical treatment with disability guidelines.

Critical checkpoints manifest themselves in four categories: *pre-injury status, diagnosis, causality,* and the *treatment plan.* Knowing the claimant's *pre-injury status* of functional capabilities is critical in establishing the baseline goal of restorable work ability. Pre-existing medical conditions, disabilities, and handicaps may create added barriers to returning the claimant to his usual and customary job. An *accurate diagnosis* is key in guiding the appropriate medical treatment of the case as demonstrated by consistency with established evidence based treatment and disability guidelines. *Causality* marks the crucial merger of the medical and legal systems within the Workers' Compensation system. The prudent determination of the work-relatedness of an injury establishes the employer's responsibility for the cost of medical treatment and indemnity. This process acts as a vital checkpoint for fraudulent claims. The *treatment plan* is the provider's tool for charting the medical and administrative course of care toward the ultimate goals of maximum medical improvement/stability and return to customary job duties. Table 1 summarizes the critical checkpoints for optimal physician, directed case management.

Treatment success is measured by timely **Maximal Medical Improvement/Stabilization** and **return to work.**[8] This does not include treating pre-existing conditions beyond pre-injury status. Assignment of injury-specific temporary total disability (TTD) should be justified in terms of optimal outcome. Clinically, the question to be asked is how does authorizing days away from work promote the desired treatment goal? Since non-medical expenditures represent the major cost drivers across the board, proper disability management of each case is just as important as first rate medical treatment.

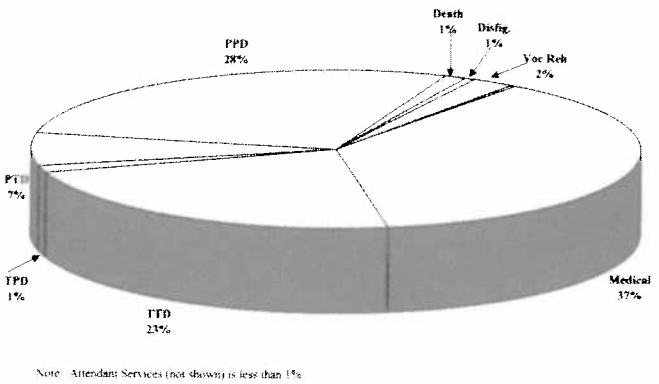
When a treatment plan is ineffective, it is usually due to inappropriate assignment of either disability, causality, or diagnosis. Medical treatment of inappropriate disability is not only ineffective but also costly, resulting in increased utilization of resources and consultations by specialists who are yet further removed from appropriate case-specific disability management. A lengthy search for anatomical or physiological pathology accountable for protracted disability behavior frequently fails. Providers are well advised to responsibly limit ineffective treatments when disability management, rather than injury treatment, becomes the primary objective. Identification of behavioral and motivational disability drivers that may be separate from the initial injury report is imperative.[9] Whenever the injured role is utilized for a secondary gain advantage, it fosters inappropriate or even iatrogenic disability. This can lead to further ineffective and/or unnecessary treatment.

Conclusions

A revised WC-2 form that structures the essential information flow described above is currently being finalized by a working committee, consisting of WC care providers, insurance carriers and Disability Compensation Division of the State of Hawaii. This standardized tool for collection and exchange of vital information will streamline decision-making in treatment planning for the injured worker.

Provider-directed disability control and improved administrative process promoting effective communication among all parties are key ingredients for optimal clinical outcomes and decreased costs.[10] Unfortunately, the present system in Hawaii often encourages

Figure 2.— 1998 Distribution of Workers' Comp Costs



Note: Attendant Services (not shown) is less than 1%

Table 1.— Critical Checkpoints of Disability Management

Critical Checkpoints	Primary Goals
1. Pre-injury Status	Extrapolate baseline functional status in and out of work environment
2. Diagnosis	Determine accurate diagnosis for appropriate and effective treatment
3. Causality	Establish work-relatedness vs. other cost liability
4. Treatment Plan	Progress to maximal medical improvement and Return-To-Work

cavalier attitudes toward early disability management that is further compromised by medical reimbursement rates that approach the lowest level in the nation. The added medical and economic value of provider-based disability management (*PBDM*) is significant and leads to improved provider case control and may well lead to higher compensation while providing timely achievement of treatment plan goals. Ultimately, State Governing Disability Compensation Boards recognize that a worker's disability management belongs in a doctor's hands rather than adrift in a lawyer's domain.

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